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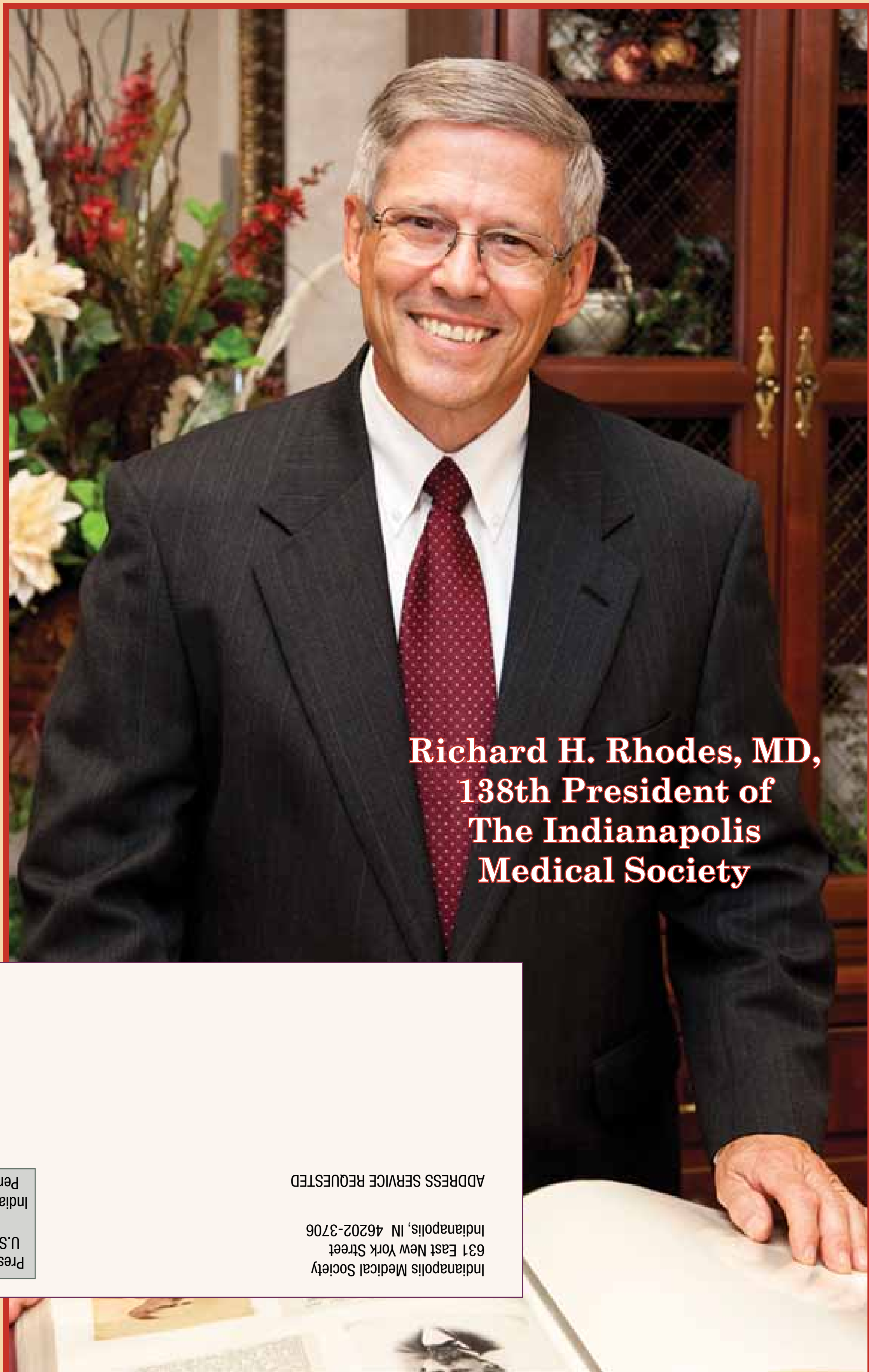

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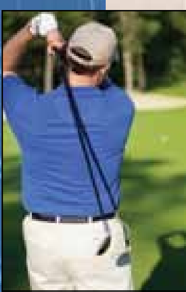

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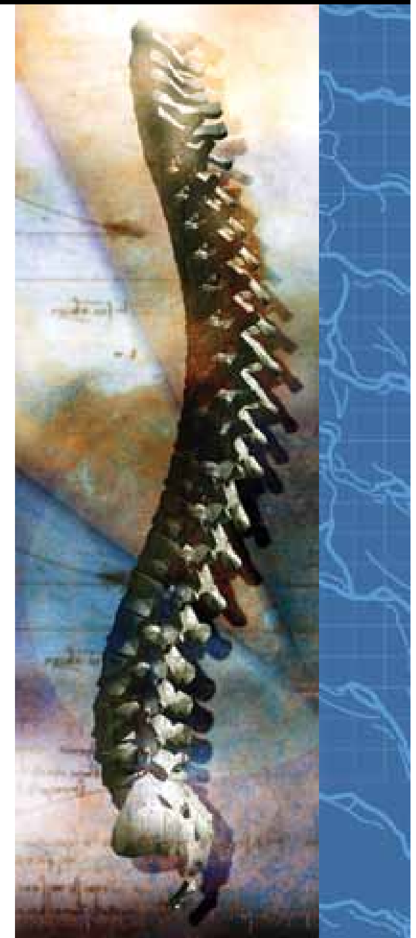

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The Bulletin is your magazine. Share your views by submitting reprints of your published articles; articles written expressly for *The Bulletin*; quips; short stories; brief comments; ideas; cartoons, etc.

Remember the *Indianapolis Medical Society Foundation* when planning your will. *(Contribution form included in this issue.)* Unless otherwise specified, your contribution will be directed toward medical scholarships.

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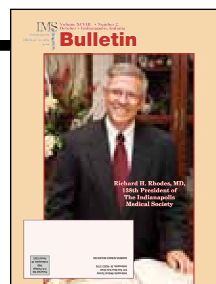
about our cover



On our cover: New IMS President, Richard H. Rhodes, MD. Dr. Rhodes' photograph shows him in the IMS Conference Center lobby reviewing the "Wishard Book."
Photograph by Debbie Winchester.

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President's Page

Richard H. Rhodes, MD

Primum non nocere

The cornerstone of the Hippocratic oath has been first do no harm to patients when they entrust their care to us as physicians. Traditionally, the Hippocratic oath has been more of a rite of passage rather than a credo or guiding document when providing care to patients. This probably makes sense given the fact that the original oath was written over 2000 years ago and the original text starts out with the words, "I swear, by the healer Apollo .... "

Indianapolis has a rich history of providing safe care for patients. In 2001, Indianapolis' hospitals came together to discuss electronic methods of sharing data about patients, all in the name of providing better care. This eventually became the Indiana Health Information Exchange or IHIE.

In 2003, this collaboration among the six major health systems or hospitals in Indianapolis (Community Health Network, St. Francis Health, IU Health, Wishard, the Indianapolis VA, and St. Vincent Health) grew into what is today known as the Indianapolis Coalition for Patient Safety (www.indypatientsafety.org). These health system Chief Executive Officers and Chief Medical Officers agreed that patient safety was not a competition; rather, patient safety should be perceived as a community directed mission. This broad view of patient safety has drawn others to the coalition's mission of "First, do no harm" including Eli Lilly & Company, the Indiana Hospital Association, Purdue and Indiana Universities, and the Regenstrief Institute.

The initial goals of the coalition were very broad and largely educational in scope. However, within a short time, the group felt the need to take action and focus on specific opportunities to collaborate. Today, the mission of the group is to "provide a forum for Indianapolis-area hospitals to share information about 'best practices' and to work together to solve patient safety issues."

In its broadest interpretation, the safety coalition is the work of caregivers. Since the time of the ancient Greeks, caring for people and preventing harm has been the foundation of medicine. In today's competitive healthcare environment, especially in Indianapolis, it is a great reminder that at its core, healthcare is about caring for patients. Even the largest competitors in Indianapolis have come together to see that in its most basic form.

The Indianapolis Coalition for Patient Safety has not been quietly sitting on the sideline during the ongoing journey to a safer health care environment. Over the past eight years, the coalition has sponsored efforts related to: high risk medications such as anticoagulants and insulin, central line blood stream infections, standardization of such things as patient wristband colors, and surgical safety.

High Risk Medications

In 2007, the coalition developed and implemented a best practice "bundle" for anticoagulants including warfarin, low molecular weight heparins and unfractionated heparin. The coalition came together regarding the use of anticoagulants following a tragic event at an Indianapolis hospital in 2006 which resulted in three patient deaths.

Another opportunity to standardize with high alert medications came about when an insulin product called Insulin U 500 began to gain popularity. The insulin, which is 5x more concentrated than traditionally supplied insulins, can cause significant confusion among both patients and caregivers.

Central Line Blood Stream Infections

In 2009, the Coalition again came together to develop and disseminate standards around the placement and use of "central lines." According to the coalition, there was evidence that patient mortality could be decreased through the use of these standards.

Standardization among Health Systems

In September of 2008, the American Hospital Association published an alert regarding the need to standardize the use of colored wristbands for patients. In hospitals, patients are often given a wristband to identify things like their drug allergy status, fall risk, etc.

An event that was published in a Pennsylvania advisory in 2005 described a patient with a yellow wristband that identified a patient as a "Do not resuscitate (DNR)" patient. The healthcare team delayed resuscitation of the patient based on the yellow wristband although it had been placed to identify the patient as allergic to a medication. The nurse that placed the wristband reported confusion from the fact that at one hospital where she worked a yellow wristband meant drug allergies while at another hospital where she worked it meant DNR. In Indianapolis, hospital wristband colors are standardized among the major the health-systems.

Surgical Safety

The coalition has worked on several projects to minimize the potential for error and patient harm in the operating room. This has ranged from developing a standard method for site demarcation for surgery to the development of standards for the prevention of post surgical respiratory depression and the use of capnography. Most recent work of this group has involved safety simulation training around a power outage in the operating room.

Indianapolis is "Accomplished" with regard to Patient Safety

The work of the Indianapolis Coalition for Patient Safety has been published and recognized at a national level. It seems only natural that the Indianapolis Medical Society would continue to be supportive of the group's work. The Medical Society's membership has also been a part of its past successes.

Don Berwick, the current administrator at the Centers for Medicare and Medicaid Services (CMS) pointed to the patient safety work done in Indianapolis when he was the President

Continued on page 30.

 – Theresa M. Rohr-Kirchgraber, MD, Julie L. Welch, MD

Cause of the doctor shortage: A rebuttal

Pointing the blame at women physicians strays from reality

The recent *New York Times* article "Don't quit this day job" by Karen S. Sibert, MD, an anesthesiologist in Los Angeles, California, makes some excellent points in recognizing that the number of physicians needed to provide care for the U.S. population is woefully inadequate.[1] Where she strays from common sense and reality is to suggest that women physicians are the reason for the shortage. Women physicians make up the majority of trainees in the primary care fields of family practice, internal medicine, and pediatrics. As the need for these fields grow, does it make sense, as Sibert implies, to limit the admittance into medical school of the one group that is becoming the primary providers of care?

In the 1970s, women were 12% of the physician workforce; by 2006, that amount increased to 27.8%. According to the American Academy of Medical Colleges (AAMC) 2009-2010 report, women now make up to 48% of the medical students and 46% of residents in training.[2] In June 2006, the AAMC called for a 30% increase in the number of entering medical students by 2015.[3] Yes, the AAMC also noted that the new generation of physicians is not willing to work the long hours worked by physicians in the past, but this comes at the same time that the American Committee on Graduate Medical Education (ACGME) instituted the 80 hour/week workforce restriction in all residency programs.[4]

The ACGME called for this restriction in 2003 and the number of hours trainees worked decreased dramatically. This focus on work force hours came out of the concern that tired, overworked physicians in training made mistakes and that with restrictions in hours and mandated rest time, patient care would improve. This change did not target women physicians or certain specialties; it was mandated across the board.

Although these restrictions started at the training level, the impact has moved to the practitioner level. During a student's and resident's education and training, there is a focus on a limited number of hours at work that is mandated. Why then would one leave training and go against that training by working 100+ hours/week? It is not the women physicians who have mandated this rule, as Sibert suggests, but the governing body for medical education. Therefore, to blame women physicians for the physician shortage is a very simplistic, shortsighted argument that does not take into account the realistic aspects of changes in training.

SINGLE, NEGATIVE GENDER MESSAGE

Sibert leaves out many important conclusions from the annual Physician Retention Surveys by the American Medical Group Association (AMGA).[5] By only focusing on women physicians who work part time or leave the profession, she succeeds in sending a single, negative gender message and leaves out many significant conclusions. The AMGA survey focuses on physician retention, including physician satisfaction and ways to address physician needs.

Donald Fisher, PhD, CAE, AMGA, president and chief executive officer, comments on the 2010 survey: "Although shortages still persist in today's physician work force, we have seen exponential growth in the size of medical groups, many of which are taking the lead in developing new care models that will increase patient access and keep physician satisfaction and retention high. Medical groups are actively addressing the needs of physicians throughout their careers, providing mentoring and leadership opportunities, and flexible work options."

It is not women physicians alone who strive for balance, but physicians as a whole. Women physicians opened the conversation about work-life balance out of necessity for flexible career options, with 85% of married female physicians having children and more than 50% giving birth to their first child during residency.[6] Additionally, 76% of women physicians report greater domestic responsibilities, especially in dual-physician couples, doing the majority of childcare and household management.[6] More female physicians (95%) have spouses who work outside the home compared with male physicians (60%).[7] However, this corresponds with 72% of male physicians now reporting a struggle to find balance between home and work, up from 12% in 1979.[6]

'PART-TIME' PHYSICIAN IS A MISNOMER

The part-time physician that Sibert describes is a misnomer. Many "part-time" physicians work 40+ hours/week, what most Americans think of as full-time! They dedicate extra time to administrative responsibilities, teaching, researching, and mentoring, on top of their "part-time" clinical patient hours.

Sibert concludes her criticism of doctors who consider work-life balance or part-time options with a troubling statement: "I think it's fine if journalists or chefs or lawyers choose to work part time or quit their jobs altogether. But it's different for doctors. Someone needs to take care of the patients." Why is it different for doctors? Doctors have the same family and societal expectations as any other professional as wives, husbands, mothers, fathers, sons, and daughters. Her implication that doctors must sacrifice their own work-life balance for the patient's sake is completely irrational. We would argue that patients actually suffer in the long run if doctors ignore their personal self-care and neglect their own work-life balance and happiness. Statistics actually show that physicians face equal to higher rates of divorce, alcoholism, drug abuse, depression, anxiety, and suicide as the general population.[8]

The AMGA survey implies that work-life balance and career flexibility are not merely gender issues, but are male and generational issues as well.[5] "Younger doctors of both genders are making the same demands that were once the domain of young mothers in medical practice," commented Joseph Scopelliti, MD, in 2009, an expert on the annual Physician Retention Survey by the AMGA.

Alice Hohl, reporting on the study, writes, "According to the study, full-time [male physicians] over age 55 and part-time [female physicians] under age 39 are at greatest risk for leaving.[8] The upside of the poor economy is that many older physicians are staying on part-time, or delaying retirement entirely, according to the study," Scopelliti says. "The big

Continued on page 26.

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Bulletin Board

Stephen R. Klapper, MD, an ophthalmic plastic and reconstructive surgeon with Klapper Eyelid & Facial Plastic Surgery, co-authored chapters on Soft Tissue Fillers for Facial Aesthetics and Enucleation and Evisceration in the latest edition of Surgery of the Eyelids, Lacrimal System, and Orbit – a monograph covering oculofacial surgery and published by the American Academy of Ophthalmology.

David L. Steiman, MD, Neurosurgical Associates of Indiana, PC, has fulfilled the requirements for the Physician's Recognition Award in Continuing Medical Education from the AMA.

Rick C. Sasso, MD, Indiana Spine Group, was an invited faculty member at the Scoliosis Research Society 18th International Meeting on Advance Spine Techniques held in Copenhagen, Denmark. Dr. Sasso lectured on treatment options regarding cervical stenosis causing myelophaty, as well as, the current status of cervical artificial disc replacements. He also moderated an instructional course lecture session on cervical motion technology.

Tod C. Huntley, MD, and Edward J. Krowiak, MD, the Center for Ear Nose Throat & Allergy, were among eight US surgeons selected for the first Advanced Techniques for Transoral Robotic Surgery (TORS) training. Sponsored by the University of Pennsylvania, and held at The Florida Hospital's robotic surgery training center in Orlando, this invitation-only lecture session and hands-on lab training was conducted on August 29-30, 2011.

Teresa M. Rohr-Kirchgraber, MD, associate professor of clinical medicine and pediatrics, will receive the AAMC 2011 Women in Medicine Leadership Development Award, which will be presented at the Association of American Medical Colleges Annual Meeting in November.

News from Goodman Campbell Brain and Spine ...

Laurie L. Ackerman, MD; Joel C. Boaz, MD; Daniel H. Fulkerson, MD; and **Jodi L. Smith, MD** published the article, "Cyst-Ventricle Stent as Primary of Salvage Treatment for Posterior Fossa Arachnoid Cysts: Report of 3 cases and review of the literature" in *Journal of Neurosurgery: Pediatrics*, May 2011.

Aaron Cohen-Gadol, MD, published the following two journal articles during August 2011: "The Use of Intraoperative Navigation for Percutaneous Procedures at the Skull Base Including a Difficult-to-Access Foramen Ovale" in *Neurosurgery* and "Neurosurgical management of congenital malformations of the brain" in *Neuroimaging Clinics of North America*.

Daniel H. Fulkerson, MD, was the featured presenter at Grand Rounds at IU Health Bloomington Hospital in July. He spoke on pediatric brain tumors most commonly seen in the primary care setting. Dr. Fulkerson published the following peer-review articles in Journal of Neurosurgery: Pediatrics in April 2011: "Intraoperative Monitoring of Motor-Evoked Potentials in Very Young (< 3 years) Children" and "Computed tomography morphometric analysis for translaminar screw fixation in the upper thoracic spine of the pediatric population."

Eric M. Horn, MD, became board certified by the American Board of Neurological Surgeons in May, 2011. Dr. Horn also co-authored these peer-reviewed articles: "Spinal surgery following organ transplantation," Journal of Neurosurgery Spine, June, 2011; "Absence of soft-tissue abnormalities in severe spinal cord injury in children," Childs Nervous System, September, 2011. He was an Invited lecturer on "Cervical Spine Anatomy" at the AO Spine Nursing and Operating Room Personnel Symposium in Indianapolis in July 2011.

Thomas J. Leipzig, MD; Daniel H. Fulkerson, MD; Troy D. Payner, MD; and **Aaron A. Cohen-Gadol** published the article, "Middle cerebral artery aneurysms in children: case series and review of the literature" in *Journal of Neurosurgery: Pediatrics*, July 2011.

Jean-Pierre Mobasser, MD, presented a case on "Minimally Invasive Navigated Lumbar Fusion" as part of the American Association of Neurological Surgeons' (AANS) national online Operative Grand Rounds Series. He also moderated the session, "Minimally Invasive Resection of Spinal Tumors" during the same series.

Troy D. Payner, MD; Andrew J. DeNardo, MD; Joel C. Boaz, MD; and Daniel H. Fulkerson, MD published the article, "'Tumor Bleeding' from a de novo Aneurysm Associated with Optic Glioma: Case Report." in *Journal of Neurosurgery: Pediatrics,* June 2011.

Laurie L. Ackerman, MD

Sunil S. Advani, MD

Joel C. Boaz, MD

Aaron A. Cohen-Gadol, MD

Andrew J. DeNardo, MD

Daniel H. Fulkerson, MD

Harry C. Genovely, MD

John D. Graham, III, MD

Eric M. Horn, MD

Tod C. Huntley, MD

Stephen R. Klapper, MD

Edward J. Krowiak, MD

Irwin N. Labin, MD

Thomas J. Leipzig, MD

Jean-Pierre Mobasser, MD

John W. Moore, III, MD

Troy D. Payner, MD

Theresa Rohr-Kirchgraber, MD

Rick C. Sasso, MD

Richard J. Shea, MD

Jodi L. Smith, MD

David L. Steiman, MD

News from Franciscan St. Francis Health ...

John W. Moore, III, MD, presented "Treatment Options for Atrial Fibrillation" on September 1 in Columbus, Indiana.

Babu S. Doddapaneni, MD, (no photo available) presented "Coronary Calcium Scoring: Identifying Cardiac Risk" on September 19 at St. Francis Health - Mooresville.

John D. Graham, III, MD, presented "How to Protect Yourself from a Stroke" on September 27 at the St. Francis Heart Center.

Continued on page 14.

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Carmel, 46032-4407
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Neurology, 2010
St. James School of Med.,
Netherland, Antilles, 2005

Bonaminio, Dana N., MD
Resident – I.U. School of Medicine
Radiology
University of Cincinnati, 2009

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Web – www.perkinsvannatta.com
Otolaryngology
Facial Plastic Surgery
Texas Tech University Health
Science Center, Lubbock, 2006

Creasap, Nicholas W., MD
Resident – St. Vincent Hospital
Family Medicine
Internal Medicine
Wright State University, 2011

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Anatomic Pathology, 1986
Cytopathology, 1989
Tulane University, 1978

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Noblesville, 46060-5005
Ofc – 621-5450*
Fax – 621-5453
Surgery 1998, 2008
Indiana University, 1991

Desai, Minesh P., DO
Resident – St. Vincent Hospital
Internal Medicine
Lake Erie College of Osteopathic
Medicine, Florida, 2011

Harrity, Andrew W., MD
Anesthesiology
Indiana University, 2007

Haste, Adam K., MD
Resident – I.U. School of Medicine
Diagnostic Radiology
Indiana University, 2010

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Emergency Medicine, 1999, 2009
University of North Carolina, 1989

Milne, Samantha L., MD
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Pediatrics
University of Nebraska, 2011

Nunez, Luis O., MD
Resident – St. Vincent Hospital
Internal Medicine
American University of the
Caribbean, 2011

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Internal Medicine, 2008
Gastroenterology
Northwestern University, 2005

Shepherd, Meredith A., MD
Resident – I.U. School of Medicine
Anesthesiology
Wright State University, 2009

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Derron Wilson, MD

Neuropsychology
Donald Layton, PhD

Bulletin Board *(Continued from page 11)*

Cardiovascular professionals attended the fourth annual Franciscan St. Francis Health Cardiovascular Symposium on September 16 at the JW Marriott in Indianapolis. The presenters and their topics included:

Saeed R. Shaikh, MD, (no photo available) "Cardiac Imaging: Next Generation Technology and Percutaneous Treatment of Structural Heart Disease"

Irwin N. Labin, MD, "Heart Failure with Preserved Left Ventricular Contractility"

Robert M. Kinn, MD, (no photo available) "Athletic Events and the Heart: Or, will I service that marathon?"

Harry C. Genovely, MD, "Molecular Biology Aspect of Heart Failure: From cell to device therapy"

John W. Moore, III, MD, "Advances in Atrial Fibrillation Management"

Sunil S. Advani, MD, "Peripheral Arterial Disease: From office screening to saving limbs"

Richard J. Shea, MD, "Decision-making in Valvular Heart Disease"

Dawn M. Salvatore, MD, (no photo available), "Carotid Artery Disease and Treatment Options"

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In Memoriam

John Michael Tondra, MD
1919 - 2011

John Michael Tondra, MD, 91, of Indianapolis, passed away at home on July 20, 2011. He was born in Canton, Ohio, the youngest of eleven children.

Dr. Tondra was a noted plastic and reconstructive surgeon in Indianapolis for many years. He was a founding member of the Ohio Valley Society of Plastic Surgeons and served as their president and historian. He pioneered reconstructive surgical procedures for hands, cleft palates, and trauma patients. He was an associate professor of surgery at Indiana University Medical School. He also travelled to provide surgical care to children in Europe and Mexico.

Dr. Tondra was a 1943 graduate of the Creighton University School of Medicine. He interned at Mercy Hospital, Canton, Ohio and completed his residency at Mercy Hospital, Canton; Madigan General, Tacoma, Washington and IU Medical Center. He served the U.S. Army as a Captain and surgeon during World War II before entering private practice in Canton, Ohio. Dr. Tondra transferred to the IMS in 1953 after moving his practice from Ohio. IMS

In Summary

Seniors' Needs Mirror Those Most At Risk

A July 2011 Research and Policy Brief from the Institute on Assets and Social Policy reveals an incredibly unsettling fact: "…more than one of every three seniors (36 percent) is economically insecure today as measured by the Senior Financial Stability Index. Combined with the 40 percent of senior households that are financially vulnerable (neither secure nor insecure according to the Senior Financial Security Index), three quarters of all senior households find themselves in an economically precarious position with little or no buffer against financial ruin should they be faced with an unexpected illness or other traumatic life event."

- Calls from nearly 10,000 central Indiana seniors (60+) echoed the needs of the larger population during fiscal year 2010/2011. Basic necessities – utilities, housing and food – ranked at the top for both groups.
- Because these are essentially financial needs, they are also some of the most difficult to meet; 47% of all seniors' unmet needs came from these 3 categories.
- Complicating the situation even more, 30% of senior callers reported that they or someone in their household had an illness or disability that added extra expenses to their budget. (The percentage of ALL callers with an illness or disability was 12%).
- The majority of senior callers (75%) were women. Most of the callers lived in Marion County. Nearly ¼ of all central Indiana calls came from 3 zip codes: 46218, 46201 and 46203. (The top three zip codes of ALL callers were 46201, 46218 and 46226).

For further information about human services needs in Central Indiana, dial 2-1-1 or 317-926-4357 or visit www.connect2help.org.

Information was provided by the Connect2Help organization serving Central Indiana. IMS

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Seated Left to Right
Morgan Tharp II, M.D.
Keith Logie, M.D.
Andrew Greenspan, M.D.
M.S. Murali, M.D.

1st Row Standing
Hillary Wu, M.D., Ph.D.
Madelaine Sgroi, D.O.
Melody Sands, APRN-BC
Danielle Doyle, M.D.
G. Irene Minor, M.D.
Tracy Price, M.D.
Elsayed Aly, M.D.

Back Row
Paul DesRosiers, M.D.
Sead Beganovic, M.D., Ph.D.
Harold Longe, M.D.
Thomas Whittaker, M.D.
Bryce Lord, D.O.
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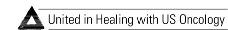

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Past President's Perspective

Indiana's Death Registration System: Worth the Effort

Indiana State Health Commissioner,
Gregory N. Larkin, MD

Beginning last January, all deaths in Indiana are now required to be recorded using the Indiana Death Registration System (IDRS). The IDRS, which was mandated by State law in 2009, is an electronic filing system aimed at increasing the accuracy of death certificates, while reducing costs and improving efficiency. Prior to that, the Indiana State Department of Health (ISDH) worked with the Indiana State Medical Association and other interested parties to craft the law so that it would be balanced in terms of responsibility for completing death certificates. As any medical professional knows, filing a death certificate accurately and in a timely manner is a critical step necessary to allow family members to mourn and heal after losing a loved one. Indiana is the only state that requires 100 percent electronic records. I am proud to say that through the use of the IDRS, Indiana is leading the way and setting an example for states who have been trying to achieve this goal for years. That is not to suggest Indiana's success has been easy for ISDH or any of its valued partners.

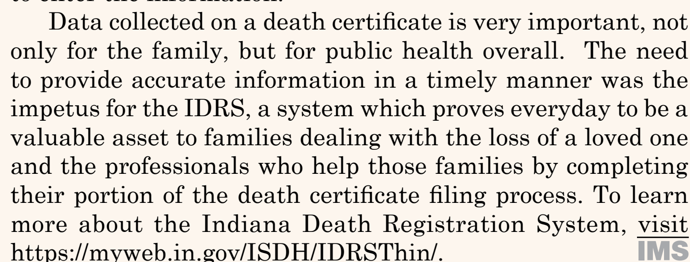
So far, the IDRS has been working as expected. Most of the calls received by the Vital Records' helpdesk about the IDRS are PIN-related or password re-sets, but we still get calls from first time users who have questions about moving through the record. The Vital Records team recognizes that this is still a new service and strives to provide the best customer service possible by returning all calls either immediately or later the same day.

An average of 250 fully electronic records are processed and filed everyday in the Office of Vital Records. In 2011 alone, more than 35,000 fully electronic records have already been filed. A random sampling of recent records indicates that it takes 3.5 days on average from the date of death until the record is fully filed. Given all the parties involved in providing information for a death certificate, this is extremely fast. In fact, before the IDRS was created, the average length of time from date of death until the record was fully filed was 13 days.

Indiana physicians have been open in sharing their opinions about the IDRS. We have had plenty of valuable and often positive feedback. Whenever feasible, we put your suggestions into action. Some changes, such as changing the time of our monthly webcast, have been fairly easy to do. Other changes have been more complicated, but well worth the effort. For example, we were recently able to amend state law so that residents may now sign a death certificate and so that a physician can initiate a death certificate rather than wait for funeral directors to do so. We are always open to suggestions, and we will make changes as we are able.

While the IDRS is working well, we do recognize that as with any new technology, familiarity and adoption takes both time and patience. The law requiring the use of the IDRS may seem more burdensome for physicians than when paper records were used, but advances in technology now allow physicians to handle this part of their business at any time, and in any place, as opposed to interrupting their scheduled patient time. This was done to create a more accountable system for reporting.

Although IDRS is a formatted, electronic data system, it does allow for variations of implementation. Some users have indicated that they rely heavily on their support staff, just like they did when it was a paper record. Others have staff complete the three screens of information, they then log in and review the information, enter their four-digit PIN and sign the record. Other feedback reveals that some physicians handle it all themselves because of how quickly they are able to enter the information.



Data collected on a death certificate is very important, not only for the family, but for public health overall. The need to provide accurate information in a timely manner was the impetus for the IDRS, a system which proves everyday to be a valuable asset to families dealing with the loss of a loved one and the professionals who help those families by completing their portion of the death certificate filing process. To learn more about the Indiana Death Registration System, visit https://myweb.in.gov/ISDH/IDRSThin/. IMS

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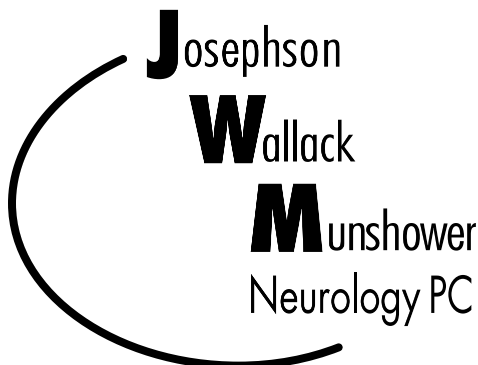

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CME & Conferences

Community Health Network

Community Hospital East

First Wednesday	Critical Care Conference Medical Staff Conf. Room, 12:00 - 1:00 p.m.
Second Wednesday	Medical Grand Rounds Medical Staff Conf. Room, 12:00 - 1:00 p.m.
Third Wednesday	Neuro Grand Rounds Medical Staff Conf. Room, 12:00 - 1:00 p.m.

Months of January, March, May, July, September, November

Community Hospital South

Fourth Thursday	Medical Grand Rounds Conf. Rooms A & B, 7:30 - 8:30 a.m.

Community Hospital North

First Wednesday	Pediatric Grand Rounds Multi Services Rooms 1, 2 and 3 7250 Clearvista Dr. 7:30 – 8:30 a.m.
First Friday	North Forum Reilly Board Room; 12:00 - 1:00 p.m.

Community Heart & Vascular/ Indiana Heart Hospital

First Wednesday	Disease Management Conference: rotates CHF & EP Case Presentations TIHH MCV Boardroom Videoconference to CHVp South Conf. Rm. 7:00 - 8:00 a.m.
Third Wednesday	Ken Stanley CV Conference TIHH MCV Boardroom Videoconference to CHVp South Conf. Rm. 7:00 - 8:00 a.m.
Fourth Wednesday	Imaging Conference: rotates Cath & Echo Case Presentations TIHH MCV Boardroom Videoconference to CHVp South Conf. Rm. 7:00 - 8:00 a.m.

Cancer Conferences 2011
Community Hospital East:

First Tuesday	East General Cancer Conference Medical Staff Conf. Room, 12:00 to 1:00 p.m.
Second Wednesday	East Chest Cancer Conference Cancer Registry Conf. Room, LL 22, 7:00 to 8:00 a.m.

Community Hospital North

First & Third Tuesday	North Multidisciplinary Breast Conference 8040 Clearvista Parkway, Suite 500, 7:00 - 8:00 a.m.
Third Wednesday	North General Cancer Conference Reilly Board Room, 12:00 to 1:00 p.m.
Fourth Wednesday	North Chest Cancer Conference Reilly Board Room, 7:00 to 8:00 a.m.

Community Hospital South

Second Monday	South Chest Conference (site specific-lung) Education Center Rooms 5&6, 7:00 - 8:00 a.m.
First Wednesday	South Multidisciplinary Breast Cancer Conference Community Breast Care Center South, 533 E. County Line Rd., Ste. 101, 8:00 - 9:00 a.m.
Third Wednesday	South General Cancer Conference President's Board Room, 12:00 to 1:00 p.m.

North Cancer Pavilion

Third Wednesday	Melanoma Cancer Conference CHN Cancer Pavilion Conf. Rm., 7:30 to 8:30 a.m.

For more information, contact Valerie Brown, (317) 355-5381.

Indiana University School of Medicine/ Indiana University Health

IU – Methodist – Riley

Oct. 3-4	Emergency Medicine and Trauma Conference for the Advanced Provider Fairbanks Hall, Indianapolis
Oct. 5	Pediatric Gastroenterology: Update on the Latest Treatment Options; Are you on the Right Track? Seasons 52 Restaurant, Indianapolis
Oct. 7	"Healthy Women, Healthy Hoosiers" Lifecourse Perspective on Women's Health Marten House Hotel and Lily Conference Center Indianapolis
Oct. 7	Successful Team Approach to Bariatric Surgery IU Health Bariatric Center, Indianapolis
Oct. 21	19th Annual Trauma/Surgical Critical Care Symposium University Place Conference Center, Indianapolis
July 20	Review and Interpretation of the 2012 ASCO Meeting University Place Conference Center, Indianapolis

Course dates and locations are subject to change. For more information, please visit http://cme.medicine.iu.edu or call 317-274-0104.

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St. Vincent Hospital and Health Care Center Inc.

Nov. 11 & 12	Back Talk: A Comprehensive Review and Practical Approach to Spinal Diagnosis and Treatment, 11.75 Credits Renaissance Hotel, Carmel Call (317) 228-7000 for more information

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CME & Events

Indiana Spine Group

Back Talk: A Comprehensive Review and Practical Approach to Spinal Diagnosis and Treatment

November 11 – 12, 2011
Renaissance Hotel, Medical Academic Center, Carmel, Indiana

Indiana Spine Group is hosting their fifth annual spine symposium. This symposium is for primary care physicians and health care practitioners, and will provide the latest information for the diagnosis and treatment of your patients with spinal problems and abnormalities. New this year are clinical workshops on Saturday. Visit http://indianaspinegroup.com/backtalk/2011/backtalk.html

To receive conference announcements and a brochure, please send your email and mailing address to info@indianaspinegroup.com or call (317) 228-7000.

This activity has been approved for AMA PRA Category 1 Credit. This activity has been reviewed and is acceptable for up to 11.75 Prescribed credits by the American Academy of Family Physicians.

Indianapolis Medical Society

October

4 IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg. Presidential Inaugural, Dr. Richard H. Rhodes

November

6 ISMA Board of Trustees, 9:00 AM, state headquarters
6 IMS Advisory Breakfast, 7:30 AM …prior to ISMA BOT
12-15 AMA Interim, New Orleans, LA
15 Executive Committee, Society, 6:00 PM, Sandwiches

December

6 IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg
14 Senior/Inactive Luncheon Meeting, Noon, Society TBD
TBA Executive Committee Dinner, with Spouses/Guests

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Project Health

Carrie Jackson Logsdon, Director

Thank you, C. William Hanke, MD

C. William Hanke, MD, Laser & Skin Surgery Center of Indiana, is Project Health's Doctor for the month of October. Dr. Hanke grew up in a small town in Iowa with one younger brother. "The public school system was very average," he says, "but my parents loved that I was able to attend a great school like the University of Iowa." "My favorite memory was my parents attending my medical school graduation. My dad was especially proud – it was like he had graduated from medical school himself that day."

Dr. Hanke also met his wife, Margaret, at the University of Iowa, who went on to get a PhD in Psychology from Purdue. They have two daughters and two sons.

For several years Dr. Hanke has been a Visiting Professor of Dermatology at UI Carver College of Medicine and endowed a Professorship in the Department of Dermatology. He completed his residency in dermatology from the Cleveland Clinic Foundation, served a rotating internship in Dallas, and then served in the U.S. Air Force Medical Corps in Hawaii for three years. He received his MPH in epidemiology from the University Of Hawaii School Of Public Health. He completed Fellowships in Dermatologic Surgery at the Cleveland Clinic and Dermatopathology from Indiana University. He is board certified in Dermatology, Dermatopathology, Laser Surgery and Mohs Micrographic Surgery.

Dr. Hanke has served as President of 11 organizations including the American Academy of Dermatology, the American Society for Dermatologic Surgery, the American College of Mohs Surgery, the Association of Academic Dermatologic Surgeons, the American Academy of Cosmetic Surgery, the International Society for Cosmetic Laser Surgeons, the International Society of Dermatologic Surgery, the Accreditation Association for Ambulatory Health Care, the Indiana Academy of Dermatology, the American Cancer Society Indiana Division and the Central Indiana American Cancer Society. His honors and awards are too many to mention, but among them are the Otis Bowen Leadership Award and the Glen Irwin, MD, Excellence Award from Indiana University; the Sagamore of the Wabash from Governor Frank O'Bannon, and most recently the Frederic E. Mohs Award from the American College of Mohs Surgery. He has authored or co-authored over 400 publications, including 91 book chapters and 20 books.

Dr. Hanke says he loved varsity athletic programs in school and that in his last year of medical school his football seats were so good that "I could nearly touch the University President." He remained active with his kids programs and he has been a member of the Indianapolis Colts Medical Team for 20 years.

Dr. Hanke says he volunteered for Project Health because of our enthusiasm for the program. "One of my Project Health patients had an enormous neglected basal cell carcinoma on the upper lip. She looked terrible. We were able to remove all of it using Mohs Surgery. The large wound was repaired using an island flap and she looked remarkably good afterwards, considering the size of the cancer. She cried in gratitude following the procedure. I almost did, too."

Thank you, Dr. Hanke for your support of Project Health and your leadership in medicine and the community. IMS

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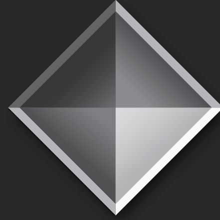

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Kathy S. Clark (2012)
John C. Ellis (2012)
Alan R. Gillespie (2012)
Robert J. Goulet, Jr. (2012)
C. William Hanke (2012)
Gerald T. Keener, Jr. (2012)
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Robert Michael Pearce (2012)
J. Scott Pittman (2012)
Bridget M. Sanders (2012)
John F. Schaefer, Jr. (2012)
H. Jeffery Whitaker (2012)

Anne C. Clark (2013)
Steven A. Clark (2013)
Carolyn A. Cunningham (2013)
David C. Hall (2013)
Ronda A. Hamaker (2013)
Stephen R. Klapper (2013)
Peter M. Knapp, Jr. (2013)
Susan K. Maisel (2013)
David M. Mandelbaum (2013)
John P. McGoff (2013)
Tim E. Taber (2013)

Mary D. Bush (2014)
David R. Diaz (2014)
Gary R. Fisch (2014)
Jonathan A. Fisch (2014)
Bruce M. Goens (2014)
Ann Marie Hake (2014)
Robert M. Hurwitz (2014)
Paul D. Isenberg (2014)
David A. Josephson (2014)
Marc R. Kappelman (2014)
E. Michael Keating (2014)
Randall A. Lee (2014)
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Richard H. Rhodes (2014)
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Nancy R. Baird (2012)
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Stephen R. Dunlop (2012)
John Duplantier (2012)
Robert S. Flint (2012)
Norrisa N. Howard (2012)
Mark U. Kyker (2012)
Terry L. Layman (2012)
Patrick J. Lotti (2012)
Mark R. Ogle (2012)
David M. Ratzman (2012)
Jeffrey M. Rothenberg (2012)
Beata E. Samuel (2012)
Steven Richard Smith (2012)
Abideen Yekinni (2012)

Robert J. Alonso (2013)
David S. Batt (2013)
Daniel J. Beckman (2013)
Craig S. Cieciura (2013)
Marc E. Duerden (2013)
Brian W. Haag (2013)
Mark M. Hamilton (2013)
Andrew A. Johnstone (2013)
Jeffrey J. Kellams (2013)
Frank P. Lloyd, Jr. (2013)
Andrew L. Morrison (2013)
David L. Patterson (2013)
Kenny E. Stall (2013)
Ronald L. Young, II (2013)

Joseph S. Buckley (2014)
William C. Buffie (2014)
Brian D. Clarke (2014)
Robert E. Dicks (2014)
Doris M. Hardacker (2014)
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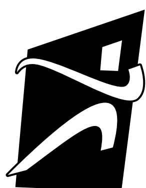

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Did You Know? *Information courtesy of AMA & ISMA*

Have Medicare patients? Watch for your notice to revalidate your program enrollment

All providers and suppliers who enrolled in the Medicare program prior to March 25, 2011, must revalidate their enrollment because of new risk-screening criteria required by the Affordable Care Act. (Providers/suppliers enrolled on or after March 25, 2011, need not revalidate.)

Why a re-enrollment? The Centers for Medicare & Medicaid Services implemented a new screening process in March 2011, part of their efforts to reduce fraud, waste and abuse.

Between now and March 2013, the Medicare Administrative Contractor (MAC)/carrier will send notices to individual providers and suppliers. Plan to begin the revalidation process as soon as you hear from your MAC. You'll have 60 days from the date of the letter to submit completed enrollment forms.

After you receive the request to revalidate, the easiest and quickest way to proceed is to use the Internet-based PECOS (Provider Enrollment, Chain, and Ownership System) system.

For more information about provider revalidation, see the cms website (http://www.cms.gov/).

CMS releases final 2012 ePrescribing penalty policy

The Centers for Medicare & Medicaid Services (CMS) made several changes to the 2012 Medicare ePrescribing Incentive Program in its final rule, released September 1. The final rule provides greater flexibility so more physicians who are unable to meet all the program requirements can be eligible and apply for an exemption to avoid penalties in 2012. CMS also extended the deadline to apply for an exemption to November 1, and physicians may now apply for more than one exemption category.

Additional details about the incentive program are available on the AMA's health information technology Web page. Physicians also can visit the AMA's ePrescribing learning center to learn about using ePrescribing in their practice, evaluate specific systems and determine practice costs. IMS

A Rebuttal *(Continued from page 8)*

issue—and everyone is struggling with it—is the generational factor."

The major difference between younger doctors and older ones, according to the AGMA survey, is workplace culture expectations that relate to work-life balance. Many younger physicians want limited on-call hours and predictable schedules. "The main thing that I've taken away is that organizations...need to learn flexibility. If you're going to be successful, you need to be flexible in how you organize work schedules," Scopelliti says.[9]

Sibert comments that it is a waste to the taxpayer if the physician does not work full time seeing patients. Yes, the costs of a medical education are borne partly by the state in most institutions, but the loan debt for a student today can be more than $200,000, hardly a free ride.[10] If physicians were required to only see patients, how then would we discover new medications and techniques? Many female physicians work in research and education. We are managers of healthcare organizations, leaders in healthcare policy, members of legislatures, and community activists. The medical degree (MD or DO) can be used for many useful purposes, of which one is seeing and caring for patients. Restricting physicians to only one purpose negates the wealth of knowledge and expertise that can be helpful for an even larger section of the population. The path to lessen the physician shortage should be to promote flexibility in work-life balance for all physicians, and to increase the overall number of physicians by increasing enrollment of U.S. students in U.S. medical schools.

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Special Feature

Pat Schmitter CPC CPC-I, VEI/IMM, ICD Expert

The Clock is Ticking!

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated the use of standard formats for electronic claims and claims-related transactions. Under HIPAA, each health plan payer has to follow standardized processes for electronic transactions. The current version 4010 format is not sophisticated enough to support new developments in health care and the upcoming ICD-10 code set changes. Therefore all electronic healthcare transactions must convert to the HIPAA-compliant version 5010 on **January 1, 2012.**

The Department of Health and Human Services (HHS) issued a final rule in 2009 replacing the current versions of the transaction standards with version 5010. Certain covered entities—including health plans, healthcare clearinghouses, and healthcare providers—must adopt the new required standards for claims, remittance advice, eligibility, and claim status inquiry. The 2009 final rule also requires the use of CPT, ICD-9 (soon to be ICD-10) and HCPCS as standard medical code sets as well as non-medical codes for such things as zip codes, state abbreviations, place of service codes, etc. All of these administrative simplifications speed the submission of consistently formatted claims and the timely reimbursement of revenues due from payers to providers of service. Version 5010 is also the gateway to implementation of ICD-10 which is effective on October 1, 2013.

The clock is ticking and the timeline for version 5010 implementation is approaching quickly. These dates are critical and if you have not heard about version 5010 until now or done anything about it yet, you need to act promptly! Please review the chart at the bottom of this page.

At the Indiana Medicare Carrier's Provider Outreach Committee (POE-AG) meeting last week, National Government Services, Inc. (NGS) gave some startling statistics. As of September 1, 2011, NGS had 12,000 active submitter identification numbers on file for all of their trading partners (doctors, clearinghouses, hospitals, and healthcare entities) who are currently submitting electronic claims for Medicare beneficiaries. Of those 12,000, only **15** (yes, that says "fifteen") have successfully completed testing and are operating in version 5010. Fifteen additional submitter identification numbers are in testing mode at this time. That leaves **11,970** submitter identification numbers that **need to test in the next 120 days!**

Today, it will take an electronic claim submitter two to four days to set up the testing process with National Government Services, Inc. If half of the 11,970 are still waiting to test on December 1, 2011 the testing process will take 45 days or more. If you have not successfully completed testing by January 1, 2012, **you will not be paid!**

Things to plan for and do TODAY:

1. **Contact** your vendors, payers, billing service, and clearinghouse
   - Ask for specific details on the installation of upgrades to your practice management system. Is your vendor ready?
   - When will they install the upgrades?
   - How much will it cost?
   - Once the upgrades are complete, you will need internal testing of your systems and staff training.
2. **If your system** is not going to be upgraded to version 5010, consider your options
   - Can you change to another clearinghouse (such as RealMed, for example) who will convert version 4010 files to version 5010 for you?
   - Do you need to consider purchasing a new practice management system?
3. **Begin external testing** with your vendors, payers, billing service, and clearinghouse
   - Contact them all and schedule testing as soon as possible
   - Testing will confirm that they are all receiving and/or sending your transactions properly
4. **Make the switch** to version 5010
   - Submit as many claims as possible prior to December 31, 2011
   - This will reduce the number of outstanding claims and increase the ability to complete payment processing for these services without disruptions
5. **Establish a line** of credit
   - Arrange access to additional funds through a financial institution to maintain cash flow if reimbursement is delayed for any length of time.
   - Limit your year-end expenditures and increase your cash reserves so you will be prepared to absorb any unexpected delays in reimbursement.

The clock is ticking and the alarm is about to ring. Make sure you are ready when the clock strikes midnight on December 31, 2011. Take action now!

Are you ready for ICD-10? The time to begin preparation for clinical documentation improvement is now. Do not waste the opportunity to improve on current diagnosis documentation in ICD-9-CM. Learning how to improve your documentation now will make the transition into ICD-10-CM much easier.

Our certified ICD-10 instructors with ICDExpert.net are here to help with your transition to ICD-10! For additional information on ICD-10 implementation or an evaluation of your ICD-10 readiness as well as training for you and your staff, please visit our website at www.icdexpert.net or call ICDExpert.net at 877-413-ICD-10.

DATE	ACTION
January 1, 2011	• Begin testing version 5010 for electronic claims • CMS begins accepting version 5010 claims • Version 4010 claims continue to be accepted
December 31, 2011	• Successful testing of version 5010 must be completed
January 1, 2012	• All electronic claims must use version 5010 • Version 4010 claims no longer accepted
October 1, 2013	• All claims must use ICD-10 codes for diagnoses and inpatient services • CPT codes continue to be used for outpatient and physician services

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Dental		Business Owners Policy
Long Term Care		Worker's Compensation
		Malpractice Liability*

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President's Page ...

(continued from page 8)

of the Institute for Healthcare Improvement. Dr. Berwick said in June, 2006,

"The outstanding work of the Indianapolis Coalition for Patient Safety is a prime example of how collaboration is accelerating change … among very competitive organizations (and) is a national model for community-based process improvement ..."

In 2009, the RAND Corporation's publication entitled "Assessing Patient Safety Practices and Outcomes in the US Hea1thcare System" reported that "... Indianapolis is perhaps the best example of a truly community-wide, collaborative approach to improving patient safety in hospitals. The key patient safety iniative within the hospital sector is the Indianapolis Coalition for Patient Safety (lCPS)."

This is no doubt that the Indianapolis Medical Society's leadership in our community and in the Indianapolis Coalition for Patient Safety has helped to accomplish physicians' fundamental need and oath *primum non nocere*. Our continued support will be needed in the future.

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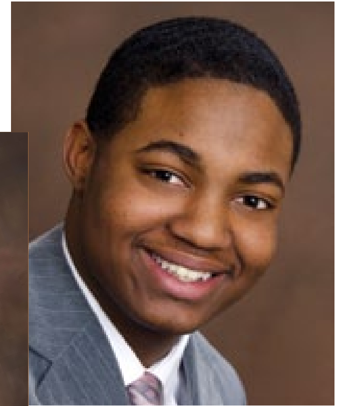

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